A collection of Recommendations and Findings of reports that serve as some of the foundational readings for OHA's Behavioral Health Workforce Initiative:

Behavioral Health Workforce Wage Study (2022) by OHSU for OHA

Findings Summary p.5 (pdf) Recs Summary p.7 (pdf)

Findings:

- There is a gap between the need for services and the capacity of the behavioral health system.
- Lack of providers and workforce turnover harms those needing services.
- Causes of the shortage of providers.
- Reimbursement rates are low for those serving behavioral health clients.
- Challenges for service users with co-occurring disorders – mental health and substance use disorder.
- Administrative burdens reduce direct contact with service users and lead to provider burnout.
- There are gaps in career advancement opportunities.

Recommendations:

- **Direct adjustments to wages**
    - Expand wage add-on programs. There are various ways the state can fund "wage add-on" programs, which effectively increase wages for eligible providers. These programs could be modeled after an existing program in Oregon's Aging and People with Disabilities Program, which increases Medicaid fees for provider organizations who agree to pay a pre-specified minimum wage to certified nursing assistants or caregivers in home and community-based settings.

    - Consider retention and recruitment bonuses. State-funded retention or recruitment bonuses may represent a short-term alternative to direct increases in wages. This approach may allow the state to target organizations with immediate unmet needs. However, this approach represents a short-term response to an underlying structural problem. Our interviews suggested that these temporary cash influxes were helpful but unlikely to motivate long-term retention of behavioral health professionals, particularly in under-resourced and community settings where case burden and demand for services continue to be high.
- **Direct adjustments to reimbursement**
    - Reform the Medicaid fee schedule for services that are under-reimbursed. The state could raise the fee schedule for behavioral health services in Medicaid's fee-for-service (FFS) program. About 10% of Medicaid beneficiaries are in Oregon's FFS ("Open Card") system, with the remaining 90% enrolled in Coordinated Care Organizations (CCOs). However, across-the-board increases in reimbursement may have unintended

consequences. Some observers indicated that some services – such as psychotherapy – are already reimbursed at a reasonable rate, while others – such as psychiatric evaluation – are not reimbursed competitively. An increase in FFS rates for selected services could compel CCOs to increase their reimbursement rates for behavioral health care, though the exact impact would need further study.

- Require or incentivize a fixed percentage of the global budget to be allocated to behavioral health. CCOs work with a global budget, which integrates financing for physical, behavioral, and oral health. This model may introduce resource tradeoffs that favor physical health or procedural-based medicine. CCO requirements could be modified to incentivize increased payments for mental health and SUD services. For example, CCOs could be required to use a specified portion of the global budget on behavioral health treatment services.

- Identify and remedy existing disparities in reimbursable activities. Behavioral health providers in Oregon indicate that current insurance systems do not support billing for certain types of services, including care coordination. These systems also fail to support billing capacities for groups of providers, including peer support providers and case managers, reducing the funds available to support wage increases for these workers. An expansion of billable services, including code modifiers that offer reimbursement for language translation or culturally specific services, may be one mechanism for increasing wages to these workers.

- Adjust reimbursement for social complexity. Adjusting reimbursement rates based on client characteristics could increase wages for providers caring for the highest need clients. Reimbursement rates could be increased for services delivered to clients with significant social risk, such as housing instability and a history of trauma. Multnomah County includes culturally specific Knowledge, Skills, and Abilities (KSAs) in job descriptions that allow for increased pay for employees who can provide bilingual and bicultural services.

- **Additional adjustments to compensation**
  - Reduce administrative burdens, claims delays, and denials. A variety of evidence suggests that providers struggle with paperwork burdens and delays or denials in payments. Oregon has already engaged in efforts to reduce administrative burdens for behavioral workers during the COVID-19 pandemic. However, our interviews also suggest a need to revisit, simplify, and streamline CCO, state, and federal reporting and documentation burdens experienced by behavioral health providers.

  - Create robust recruitment and training pathways. Providers reported under-resourced training environments, which could be bolstered through dedicated funds, either to provider organizations or to trainees directly. Additional funding could be used for internships and externships, professional development and mentoring, and specialized

training pathways. Many people noted the need for diversity in leadership, which could help to support the recruitment and retention of a diverse workforce more broadly. It may be beneficial to adopt a wage or rate premium to support bilingual professionals, culturally specific positions, or other specialized services that often involve additional, currently unpaid work. A robust recruitment strategy needs to begin earlier in the career pipeline, including outreach to secondary schools, community colleges, and universities to strengthen interest in behavioral health professions.

- Encourage transparent pay scales and promotion practices. More transparent wage scales and promotion structures permit reliable salary comparisons within and across industries and have been shown to improve workforce retention and encourage further training and career progression. Career advancement and job promotion opportunities may have a more pronounced effect on job satisfaction and retention than a higher minimum starting wage.

- Expand tuition reimbursement and loan repayment programs. Oregon's Health Care Provider Incentive Program includes loan repayment programs for behavioral health providers. The 2021 legislature passed HB 2949, which included additional funding for loan repayment and tuition reimbursement programs, focusing on people of color, tribal members, or residents of rural areas who can provide culturally responsive behavioral health services. These programs can directly incentivize workforce pipeline development by reducing barriers to further training and indirectly increasing the amount of disposable income for behavioral health providers.

- **Additional recommendations**
  - Improve the work environment. Providers universally cited high case burden and acuity, intensive and inflexible schedules, frequent rotations on crisis calls, and insufficient supervisory support as negatively impacting their job satisfaction. Improvements to the workplace could include expanded benefits such as health insurance, housing stipends, moving stipends, childcare, family leave and paid time off, and other options such as scheduling flexibility, rotating call, and occasional remote work. Creating the internal infrastructure to provide trauma-informed support for the workforce is likely to be essential for staff retention. Institutional and state guidance and oversight of these work conditions may help to reduce workforce burnout.

  - Review existing licensure requirements. Oregon's approach to staffing behavioral healthcare needs has been to encourage the use of unlicensed professionals. This approach is intended to reduce barriers to hiring providers. However, large pay differences between unlicensed and licensed workers may exacerbate turnover, with unlicensed workers leaving their current employer when they obtain licensure to earn higher wages in a different setting. This structure creates scenarios where individuals with the least amount of training care for clients with the greatest needs.

- Review regulations that inhibit recruitment. Oregon could consider changing current licensing requirements regarding reciprocity with other states. State regulations require approximately six months for an out-of-state provider to obtain licensure to practice in Oregon. Requirements that employees pass background checks may reduce the opportunities to become peer workers for people with previous criminal justice system involvement.

- Assess and remediate regional wage differences in Oregon. There are significant regional variations in wages for substance use and mental health counselors. For example, the highest median wages occur in the South Coast area, with median wages ($32.07) that are almost 70% higher than the South Central area's median wage of $19.82. It is unclear why such large variations exist, though factors like regional competition and cost of living could contribute. Understanding the causes of these differences may create opportunities for addressing wage disparities in the state. The available data on wages did not allow for analysis by race/ethnicity, so these data sources should be augmented using OHA's REALD (race, ethnicity, language, disability) and SOGI (sexual orientation, gender identity) standard.

- Commit to a diverse workforce and draw from the community. Shortages of providers of color and others from underrepresented communities can be self-reinforcing. Increased representation can lead to greater success in recruiting diverse candidates. The state and health systems should include providers of color in developing their processes, policies, and outreach because these voices may have unique insights into challenges with work conditions, billing codes, and recruitment and retention. Many people noted the need for diversity in leadership which could help to support the recruitment and retention of a diverse workforce more broadly. To translate these priorities into action, it may be beneficial to adopt a wage or rate premium to support bilingual professionals or culturally specific positions.

CCC Behavioral Health Report Oregon (2021)

Recs on p.46 (pdf)

Reality: Majority of BIPOC people receive behavioral health care from religious figures, traditional healers, community-based organizations and clinics

Action: Partner with, defer to, and compensate trusted culturally specific leaders and BIPOC-serving organizations

Reality: BIPOC people do not utilize behavioral health services because there are not enough multilingual and multicultural providers

Action: Invest in building a workforce of BIPOC health care workers and providers, and ensure that clear career paths are available, secure, and sustainable

Reality: BIPOC people experience high rates of racism, discrimination, and bias in medical settings

Action: Invest in culturally responsive training and practices for accommodating cultural realities for health care providers

Crisis de Nuestro Bienestar Oregon (2020)

Starting p.20 (pdf)

Access Recommendation 1: Increase systemic resources and implement policy and organizational structures for Latinos/as/x and rural populations to address the scarcity of mental health providers and build support for those providers.

• Build in differential financial incentives for bilingual, bicultural mental health

provider recruitment.

• Create a Latino/a/x mental health collaborative across all university systems to prepare future

bilingual and bicultural Latino/a/x mental health providers and peer-to-peer counselors.

Critical work for this collaborative will be developing and maintaining a Latino/a/x peer mental

health specialist certification program.

• In the short term, systematically maximize the roles and use of all mental health providers

that fill this lack by applying the designation of "mental health provider" and its associated

health care coverage to include:

» Qualified mental health associates (QMHAs), which include unlicensed peer-to-peer

counselors and community services

» Qualified mental health professionals (QMHPs), which include unlicensed social workers,

nurse practitioners of psychology, psychiatrists, psychologists, mental scientists and

therapists, and

» Licensed interns.

• For the long-term, the Latino/a/x mental health task force will advise strategy to take

regarding the "mental health provider" designation and its associated health care coverage.

(See Implementation Recommendation #3 below) with engagement of relevant Oregon

licensing boards.

Oregon Substance Use Disorder Services Inventory and Gap Analysis (2022)

Recs on p.8 (pdf)

- Address gaps in substance use disorder workforce, including both prescribers and credentialed staff providing essential prevention services and recovery supports.
- Increase support for service organizations to employ and bill for certified peer support specialists across the continuum of substance use disorder care.
- Expand LGBTQIA2S+ specific services, particularly recovery services for youth who are at high risk for substance misuse and substance use disorder as compared to their cisgender, heterosexual peers and may benefit from targeted services.

ASWB (Social Work licensing Exam) National Pass Rate Analysis (2022)

Discussion p. 69 (pdf)

Demographic changes in the test-taker population
Several findings show that the proportion of test-takers from historically marginalized communities (defined for this report as those reporting their race/ethnicity as Asian, Black, Hispanic/Latino, multiracial, or Native American/Indigenous peoples) increased from 2011 to 2021. This finding suggests that more test-takers from these communities are actively seeking social work licensure. The proportion of white test-takers, however, remains the largest across the exams. Similar trends can be observed when examining the proportion of test-takers by gender. Most test-takers—like most social workers—are women.

Pass rates by race/ethnicity
Across all five exams, differences were observed in pass rates among racial/ethnic subgroups, the largest being between white test-takers and Black test-takers, who tend to have the lowest pass rates of all racial/ethnic groups.

Variations in exam performance across different racial/ethnic groups are not unique to the ASWB examinations. Other professional licensure tests, such as the Praxis® exam for teacher licensure (Nettles et al., 2011), Nursing Council Licensure Exam (NCLEX-RN®; Lockie, 2013), the North American Pharmacist Licensure Examination (NAPLEX®; Chisholm-Burns et al., 2017), and the bar exam (American Bar Association, 2022) have also reported different pass rates for historically marginalized groups, suggesting systemic issues affecting all licensure candidates.

Pass rates by age
Another trend observed in the data concerns differences in pass rates based on the age of test-takers. Specifically, test-takers in the lowest age category—those between the ages of 18 and 29 years old—tended to have higher pass rates than test-takers in higher age categories, particularly those over 50 years old. Test-takers of any age may have unique challenges based on multiple factors and responsibilities, including family, finances, and other commitments outside their profession that may

make it difficult to prioritize exam preparation. However, the findings suggest that social workers in higher age categories may be experiencing these challenges at a higher rate than their counterparts in lower age categories. Test-takers who recently graduated from a social work program may be more likely to pass the exams compared to test-takers who, despite being experienced professionals, may have graduated from social work school years earlier and are less likely to have benefited from recent instruction specifically targeted at preparing for the exam.

Pass rates by demographic intersections

Test-takers represent combinations of specific demographic characteristics (e.g., race/ethnicity, gender, gender identity, age, disability, primary language), the intersections of which often result in additional, multiplicative hardships for individuals and groups (Crenshaw, 1989). For example, while Black test-takers tended to have lower pass rates when compared to test-takers from other races/ethnicities, pass rates for Black male test-takers were lower than pass rates for Black female test-takers. A similar trend was observed when comparing Black test-takers in higher age categories to Black test-takers in lower age categories. On the other hand, for certain exams (e.g., Clinical, Masters), the gender differences in pass rates are smaller for Hispanic/Latino test-takers compared to test-takers from other historically marginalized groups.